

115TH CONGRESS  
1ST SESSION

# H. R. 3752

To direct the Secretary of Veterans Affairs to develop and implement plans to improve the safety of medical facilities of the Department of Veterans Affairs, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 12, 2017

Mr. NORCROSS (for himself and Mr. COSTELLO of Pennsylvania) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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## A BILL

To direct the Secretary of Veterans Affairs to develop and implement plans to improve the safety of medical facilities of the Department of Veterans Affairs, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Policies to Address  
5 Tragic Injuries Enabled by Never events Thoroughly Act”  
6 or the “PATIENT Act”.

7 **SEC. 2. FINDINGS.**

8 Congress finds the following:

1           (1) Never events continue to occur in the health  
2           care system of the Department of Veterans Affairs  
3           and remain a growing source of patient morbidity.

4           (2) Despite their importance, never events seem  
5           to persist as an unsettled issue across the Nation.

6           (3) In 2016, a national survey announced that  
7           “One in Five U.S. Hospitals Fail to Adopt Crucial  
8           Never Events Policies.”.

9           (4) The Department lacks a mandated report-  
10          ing system for never events that would help quantify  
11          this problem.

12          (5) Never events, such as operating room fires,  
13          including those caused by unsafe laser fiber prac-  
14          tices, pose serious risks, such as injuries or burns  
15          that can be severe and permanent, to both patients  
16          and health care professionals.

17          (6) The Department does not currently have a  
18          comprehensive operating room fire safety policy in  
19          place to improve operating room safety.

20   **SEC. 3. IMPROVEMENT OF SAFETY AT MEDICAL FACILITIES**  
21                   **OF THE DEPARTMENT OF VETERANS AF-**  
22                   **FAIRS.**

23          (a) PLANS.—The Secretary of Veterans Affairs, act-  
24          ing through the Veterans Health Administration, the Na-

1 tional Surgery Office, and the National Center for Patient  
2 Safety, shall develop and implement the following:

3 (1) A comprehensive, system-wide plan to de-  
4 crease never events that incorporates technological  
5 tools.

6 (2) A comprehensive operating room fire safety  
7 plan that requires—

8 (A) the reporting of operating room fires;

9 (B) the inclusion of the directives outlined  
10 in the 2011 fire safety alert of the Food and  
11 Drug Administration to mitigate risks relating  
12 to fires; and

13 (C) the carrying out of a pilot project that  
14 tests and validates new operating room fire  
15 safety technology at multiple medical facilities  
16 of the Veterans Health Administration.

17 (b) REPORT.—Not later than 90 days after the date  
18 of the enactment of this Act, the Secretary of Veterans  
19 Affairs shall submit to Congress a report containing the  
20 plans developed under subsection (a).

21 **SEC. 4. NEVER EVENT DEFINED.**

22 In this Act, the term “never event” means an event  
23 involving the delivery of (or failure to deliver) hospital care  
24 or medical services furnished at a medical facility of the  
25 Department of Veterans Affairs in which there is an error

1 in the care or services that is clearly identifiable, usually  
2 preventable, and serious in consequences to patients, and  
3 that indicates a deficiency in the safety and process con-  
4 trols of the care or services furnished with respect to the  
5 physician or medical facility involved. Such term includes  
6 operating room fires.

